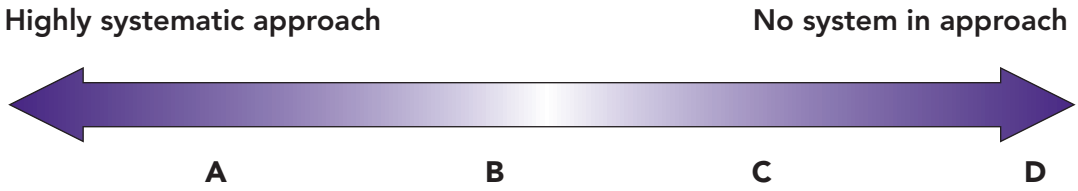
Advance care planning continuum of practice explained

Rather than classifying facilities into whether or not they undertake ACP, it is more useful to describe advance care planning practices along a continuum, with all facilities falling somewhere along this. The main characteristic of the continuum is how routinely and systematically advance care planning is approached by facility staff. Ways this characteristic can be understood are in terms of the initiation, scope, follow-up and documentation of ACP, as well as the organisational leadership adopted around ACP.

While stressing these categories are NOT clear cut and objectively measurable, the authors suggest there are four broad approaches to ACP along this continuum, as described under approaches A-D below. Facilities can use this model to chart their current practice and identify areas where changes may be warranted.



	A	B	C	D
Initiation	ACP information is given routinely to all new residents or family	ACP is not raised explicitly but may be subsumed into general discussions with resident or family	Some written ACP information may be given but there is no discussion initiated by staff	There is no ACP information given or discussion initiated by staff
Scope	Clarifies substitute decision-maker, personal values and treatment preferences in possible future scenarios	Some discussion of treatment preferences in possible future scenarios	No discussion of treatment preferences in possible future scenarios unless the resident is quite sick	No discussion beyond issues such as funeral arrangements
Follow-up	Systematically includes ACP discussion in post-admission case conference. Refers back to ACP in later treatment decisions	Tries to include ACP in post-admission case conference but not done systematically and often does not happen	No follow-up initiated by staff. They will respond if resident or family raise ACP issues	No follow-up initiated by staff. Discussion occurs only in response to serious illness
Documentation	ACP discussions and directives are recorded in specific and obvious part of	ACP discussions are recorded with general admission data or case conference notes	There is no specific ACP documentation Any discussion that may occur is	There is no documentation at all of ACP discussions or residents'

	the notes and accompany resident to hospital	but is not routinely sent with person to hospital	only written in progress notes	treatment preferences
Organisational leadership	Facility manager and other senior staff see ACP as a priority and are strong role models. Clear policies and staff training	Facility manager is interested in developing ACP and is making an effort to develop policies. No consistent approach or training yet	Facility manager has some understanding of ACP but does not see it as a priority and is too swamped to find out more at the moment	Facility manager does not understand what ACP is about and is not really interested in finding out about it
"In a nutshell"	"I am very keen and am making an effort to do it now"	"I am fairly interested and would like to find out more"	"I could be interested but am too busy at the moment"	"I don't really know what you are talking about"

Reference: Shanley C, Whitmore E, Khoo A, Cartwright C, Walker A, Cumming R.G. (2009) Understanding how advance care planning is approached in the residential aged care setting: A continuum model of practice as an explanatory device. *Australasian Journal on Ageing,* 28(4), 211-215.

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